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ABSTRACT

Three revolutions in the history of mental health were identified by Nicholas Hobbs: the humane revolution, the scientific and therapeutic revolution, and the public health revolution. The shift of responsibilities for mental health and substance abuse services from the public to the private sector may constitute a fourth mental health revolution. The public-private issue can be viewed from two historical vantage points: developments in American medicine and specific developments within mental health. The reprivatization of medical care in America involves a change in type of ownership and control; horizontal integration; diversification and corporate restructuring; vertical integration; and industry concentration. In the field of mental health, recent developments have been toward reprivatization and deinstitutionalization. There are differing views on what values will be emphasized as a result of the reprivatization of mental health, but the reassessment of public and private responsibility should be pursued within the context of history. The sense of realism and caution that history demands should prevail as the public interest in mental health is sought. (NB)

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PUBLIC AND PRIVATE RESPONSIBILITY FOR MENTAL HEALTH: MENTAL HEALTH'S FOURTH REVOLUTION

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TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Does the apparent shifting of responsibilities for mental health and substance abuse services from the public to the private sector constitute a fourth mental health revolution? My late friend and colleague at Vanderbilt, Nicholas Hobbs, over 20 years ago identified three revolutions in the history of mental health. In the first, the humane revolution, Pinel struck the chains of the insane during the French Revolution and Dorothea Dix lobbied for the asylums in America. The second, the scientific and therapeutic revolution, was ushered in by Sigmund Freud and those who made breakthroughs in psychological research and treatment. The third, the public health revolution, was marked by the rise of the community mental health movement. Does the rise of the private sector, what in general medicine Paul Starr (1982) has called "the reprivatization of the public household," constitute a fourth revolution? And if so, will it serve the public interest?

The public-private issue should be viewed from two historical vantage points: that of developments in American medicine and that of the specific developments within mental health.

General Medical Developments

Let us begin by looking at reprivatization in the context of recent developments in the general medical scene. Arnold Relman (1980) of the prestigious New England Journal of Medicine identified what he calls "the new medical-industrial complex." Although Relman doesn't label this phenomenon as a revolution, his rhetoric suggests that he believes it is, for example, when he says that it "is an unprecedented phenomenon with broad and potentially troubling

implications for the future of our medical-care system" (p. 963).

Paul Starr (1982) described this and related phenomena as "the social transformation of American medicine." He argued that

> the last decades of the twentieth century are likely to be a time of diminishing resources and autonomy for many physicians, voluntary hospitals, and medical schools... [related to]...the rapidly increasing supply of physicians and the continued search by government and employers for control over the growth of medical expenditures. These developments may prepare the way for the acceleration of the rise of corporate enterprise in health services. (p. 421)

So Starr argues that:

> Medical care in America now appears to be in the early stages of a major transformation....This transformation--so extraordinary in view of medicine's past, yet so similar to changes in other industries--has been in the making, ironically enough since the passage of Medicare and Medicaid. By making health care lucrative for providers, public financing made it exceedingly attractive to investors and set in motion the formation of large scale corporate enterprises. (p. 428)

The reprivatization of medical care in America also entails "changes in the organization and behavior of nonprofit hospitals and a general movement throughout the health care industry toward higher levels of integrated control" (p. 429). Starr identified five dimensions of this general movement characterizing recent history:

1. Change in type of ownership and control: the shift from nonprofit and governmental organizations to for-profit companies in health care.

2. Horizontal integration: the decline of freestanding institutions and the rise of multi-institutional systems, and the consequent shift in the locus of control from community boards to regional and national health care corporations.

3. Diversification and corporate restructuring: the shift from single-unit organizations operating in one market to "polycorporate" and conglomerate enterprises, often organized under holding companies sometimes with both nonprofit and for-profit subsidiaries involved in a variety of different health care markets.

4. Vertical integration: the shift from single-level-of-care organizations, such as acute-care hospitals, to organizations that embrace the various phases and levels of care, such as HMOs.

5. Industry concentration: the increasing concentration of ownership and control of health services in regional markets and the nation as a whole. (p. 429)

Mental Health Developments

Turning now to the history of mental health in America, there have been political-economic and institutional cycles (Dokecki & Mashburn, 1984). Before 1830, mental health care was mostly a private or local matter, provided in mostly noninstitutional or community settings. By 1830, a consensus began to emerge that care of the mentally ill was a public matter, and Americans built

the first public asylums. From that time until the modern era, these state institutions dominated the mental health system. For their first 25 years, the asylums were apparently very successful; however, thereafter until the middle of the 20th century, they were little more than human warehouses. After World War II, the federal government entered the public institutional arena, and during the last several decades, public institutions have both been upgraded in quality and reduced in population, with a concomitant increase in community programs. This claimed movement toward deinstitutionalization has been intertwined with the emergence of the private sector. We seem to be coming full circle: We started with private and noninstitutional policies; we now seem to be evolving toward reprivatization and deinstitutionalization.

What is the evidence on the interrelated cycles of reprivatization and deinstitutionalization? On the global issue of deinstitutionalization, certain generalizations can be made about the last decade or so.

1. Although total hospital inpatient days for individuals with a primary diagnosis of mental disorder have decreased, psychiatric hospitalization still accounts for about 25% of all hospital days in the U.S.

2. The rate of hospitalization episodes for patients with a primary diagnosis of mental disorder has increased.

3. Except for state mental hospitals and VA psychiatric hospitals, the length of stay of psychiatric patients has been stable.

How do these trends relate to the claim that there is a deinstitutionalization movement? Charles Kiesler (1982) has maintained that

> Our national de jure policy is the development of outpatient care and deinstitutionalization. The policy of developing outpatient care, at least, has been quite successfully implemented....There has been a twelvefold increase in outpatient services over the course of 20 years. The centerpiece of this effort has been the community mental health center system....Deinstitutionalization has been more controversial, although many feel it has been clinically successful....However, our national de facto policy in mental health is hospitalization. NIMH reports that over 70% of mental health money is spent on hospitalization. (p. 1323)

Hospitalization, what many would continue to call institutionalization, then, is the de facto mental health policy in the U.S.

In order to understand the related issue of reprivatization, we must look inside these provocative data on deinstitutionalization. Again, Charles Kiesler leads the way.

Regarding the first point mentioned earlier, that total hospital inpatient days for psychiatric problems have decreased, what must be stressed is that this decrease is accounted for almost entirely by decreases in state mental hospitals and VA psychiatric hospitals. With the exception of a slight decrease in nonprofit private mental hospitals, all other sites have increased, most

importantly, general hospitals (up 99% from 9.7 million days to 19.4 million days). As Kiesler and Sibulkin (1983) have commented: "General hospitals are now the most likely place to be hospitalized for mental disorders" (p. 610). And, of course, most general hospitals are in the private sector, with a recent dramatic increase in those owned by for-profit, multiple-facility organizations.

The second finding, that the rate of psychiatric hospitalization episodes has increased, is controversial. It contains within it the generally reported finding that the rate of hospitalization has been stable across virtually all service sites. But one service site, the general hospital without a psychiatric unit, has not been included in the typical report. When it <u>is</u> included, the usually reported stable episodic rate changes markedly, and Kiesler reports a steady linear increase from 1965 to 1979. "More inpatient episodes for mental disorders occur in general hospitals without psychiatric units than any other site...and this population of patients is rapidly growing" (Kiesler & Sibulkin, 1984, p. 48).

About the third point mentioned earlier, that length of stay for psychiatric hospitalization has been stable, it must be pointed out that there have been major decreases in two sites, the state mental hospital and the VA psychiatric hospital.

Let us pause for a moment to recapitulate these recent historical data. The U.S. <u>has</u> implemented a policy of developing outpatient services, with a manifold increase over the past 20 years, led by the community mental health centers. Hospitalization

or institutionalization, nevertheless, still seems to be our de facto mental health policy; however, deinstitutionalization of sorts, has characterized the public sector.

The private sector, for its part, seems to be heavily implicated in both the development of outpatient services and in the seeming de facto hospitalization or institutionalization policy. The data so far presented underscore the growing importance of the private sector in mental health. But Goldman and his colleagues offer important correctives saying that

> The evidence suggests that whole new classes of previously untreated patients are now using services that were not available 10 to 20 years ago. The often claimed shift in the locus of care is more accurately a shift in the focus, or relative emphasis, of care. Policies focusing primarily on community-based care have encouraged the expansion of new mental health services that have not adequately served the needs of chronic patients. (Goldman, Adams, & Taube, 1983, p. 130)

Goldman et al. commented further that:

> Of all the organized health care settings, only the nursing home can be demonstrated clearly to have become a substitute for the long-term custodial care function of the state and county mental hospital (p. 132)....However, there...appears to be a core of some 100,000 resident patients for whom there is no alternative to state hospital treatment. The state

> facility has remained the place of last resort for patients who are either too disturbed or too disturbing to be placed in the currently available types of residential alternatives. (p. 133)

Goldman et al. also identified a related troublesome myth: That costs for mental health services have shifted from public to private resources:

> The introduction of Social Security benefits, including Supplemental Security Income (SSI), Medicare and Medicaid, has, in many cases, only shifted portions of the financial burden for psychiatric care from local and state governments to the federal government.
>
> Thus costs have shifted from one public resource to another and not from public to private resources. (p. 133)

Leaving cost concerns, precise data on trends in private sector provision of mental health services are difficult to come by. Levenson (1982) presented data and the claim that, "as a result of their impressive growth, investor-owned psychiatric hospitals have come to be the dominant form of nongovernmental free-standing hospital in the United States" (p. 902).

Initiated in the late 1960s, investor-owned multi-hospital systems now total about 30. Four of these firms command the chain-affiliated psychiatric hospital market. As Levenson (1983) pointed out:

> Several factors have contributed to the growth of the

> investor-owned multi-hospital chains, particularly the chains' ability to acquire the capital financing needed to construct new facilities, to acquire existing facilities, and to purchase equipment. The proprietary nature of the investor-owned chains and their growth into large corporations has enabled them to attract substantial interest among investors, primarily through public stock offerings. The larger the firm, the better its ability to use such equity financing....In addition...the investor-owned chains have been able to generate substantial amounts of capital through bank loans and other forms of commercial borrowing. (pp. 1128-1129)

The proprietaries of the 1960s were single facility hospitals. From the 1960s to today, multi-hospital chains have emerged and currently control the vast majority of investor-owned institutions.

The recent growth of the chains is running into the availability of facilities. The chains have come close to owning all existing psychiatric proprietaries. Schlesinger and Dorwart speculated that continued growth will necessitate that the chains either construct new facilities or, perhaps more attractive to them, acquire existing facilities in the nonprofit and public sector. The net result "may well 'shift the balance' that currently exists among proprietary, private nonprofit and public facilities and thus alter the overall performance of the mental health care system in this country."

Value Issues

So much for the data, now to some issues, especially value issues. It is crucial to realize that throughout history mental health has been more of a welfare or dependency issue than a medical one, especially where the chronically mentally ill have been concerned. In America, we value rugged, independent people who are able to survive, thrive, and pay their way--a value most clearly manifested in ninteenth century Social Darwinism, survival of the fittest. We wish to be protected from dependent and deviant people and sometimes seem to care little about their survival. But there is a streak of conscience in the American character. We operate according to Social Darwinism with a conscience. But there is a war between conscience and our economically-influenced concern for convenience, producing public ambivalence that has led to a remarkably inconsistent pattern of mental health policy. Funding is always an issue, and priorities are constantly shifting. How will reprivatization affect mental health funding and priorities?

Within this economics-dominated context, we speak of treatment, cure, human development, and social integration. The deciding issues, however--usually only implicitly expressed--concern custodial care and protection of the public. Ambivalence and unacknowledged value conflicts, therefore, are the stage upon which the drama of mental health public policy development occurs. What values will be emphasized as a result of the reprivatization of mental health? And will the public interest be served?

Value-based arguments swirl about the public-private issue. Here are two ideological extremes. First, the view of an American radical social scientist, Andrew Scull (1984, p. 150):

> Particularly in America, an effort is underway to transform 'social junk' into a commodity from which various 'professionals' and entrepreneurs can extract a profit. Medicare and the nursing home racket are merely the largest and most blatant examples of this practice....There have appeared whole chains of enterprises..., including fair sized corporations sprawled across several states dealing with...discharged mental patients. Largely free of state regulation or even inspection, and lacking the beureaucratic encrustations of state-run enterprises, such places have found ways to pare down on the miserable subsistence existence characteristically provided in state institutions.... [W]hat is important about these places is that while, in an obvious sense, they are the creatures of changes in state policy; yet on another, admittedly secondary, level they came to provide one of the policy's political supports and a source of pressure for its further extention.

On this view, reprivatization jeopardizes the public interest.

The other polar statement, ironically enough written by Arnold Relman, although he doesn't subscribe to it, describes the theory of the market's operation in health care. Says Relman (1980, p. 966) in theory:

> The free market should operate to improve the efficiency and quality of health care. Given the spur of competition and the discipline exerted by consumer choice, private enterprise should be expected to respond to demand by offering better and more varied services and products, at lower unit costs, than could be provided by nonprofit voluntary or governmental institutions. Large corporations ought to be better managed than public or voluntary institutions; they have a greater incentive to control costs, and they are in a better position to benefit from economies of scale. We Americans believe in private enterprise and the profit motive. How logical, then, to extend these concepts to the health-care sector at a time when costs seem to be getting out of control, voluntary institutions are faltering, and the only other alternative appears to be more government regulation.

On this view, presented but disputed by Relman, reprivatization is the salvation of the public interest in mental health.

The truth is probably someplace between these polar views. Schlesinger and Dorwart (1984) observed that the public and private sectors and their differing interests need

> not be in fundamental conflict, that a system can be shaped which relies solely on neither one nor the other. It is equally important to understand that such a balanced system will not necessarily evolve through natural selection or the

workings of the "Invisible Hand." It must be carefully developed as a part of a system which reflects the heterogeneous needs of the mentally ill and the diverse motivations of those who seek to provide them with care. Only careful development will contribute to the public interest. In Charles Schultze's (1977) phrase, we should pursue the "public use of the private interest" to balance direct public sector activity.

Are we experiencing mental health's fourth revolution? I think we probably are, but revolution or not, it is within the context of history that reassessment of public and private responsibility should be pursued. The sense of realism and caution that history forces on us should prevail as we seek the public interest in mental health.

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